THE

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OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

PODIATRISTS

THE OFFICIAL PUBLICATION OF THE PROFESSION

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MARCH
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NO. 3

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VOLUME 35 MARCH, 1945 NUMBER 3

TRENCH FOOT*

TRENCH FOOT has again loomed into importance as a factor contributing to noneffectiveness, this time on the very fighting front where in the last war the British suffered so heavily from this condition. Despite the experience of the last war and the experience in Italy last winter, adequate control of trench foot is yet to be attained. The basic principles of a satisfactory control program are:

1. Provisions of suitable equipment. Loose-fitting waterproof or water-resistant boots with thick, replaceable, felt innersoles and woolen socks may be best under certain conditions. However, even with existing footgear, adequate protection against trench foot can be achieved by careful observance of the measures listed below.

2. Avoidance of unnecessary risk.

a. Standing in water or mud-soaked areas should be avoided as much as possible.

b. Cramped positions, prolonged immobility, and dependency of the extremities should be avoided. These can be counteracted by stationary exercise of the feet and legs.

c. In cold, wet weather, troops should be rotated and relieved from front-line duty as often as the tactical situation permits.

3. Enforcement of adequate individual hygiene.

a. Wet socks or innershoes should be changed to dry ones as often as possible. Troops should carry a dry, extra pair at all times.

b. Shoes should be removed at least once daily, and the feet cleaned and dried.

c. The upper part of the body should be kept as warm and dry as possible.

d. Noncommissioned officers must be prepared to supervise their men in the care of their feet. Frequent inspections by unit commanders will be valuable in enforcing proper foot hygiene and also in detecting early clinical manifestations of the injury when men are exposed to trench foot.

Apart from the provision of equipment, control rests with the individual himself. The measures to be taken are elementary but relatively unfamiliar to soldiers without either appropriate pre-combat training or

combat experience on cold, wet terrain, and they require diligent application to be effective. An otherwise well conceived and executed control program can be defeated as it sifts down the chain of command unless all echelons enforce individual hygienic measures and foster policies of relief and rotation calculated to minimize exposure. Daily foot inspections by commissioned or noncommissioned officers and enforced exercise and change of footgear exemplify the type of rigorous surveillance which is difficult to ensure yet must be attained if control is to be achieved.

For its development, trench foot does not require freezing temperatures. Continued exposure in cold, wet trenches or foxholes, with restricted movement, and the wearing of wet socks and footgear without change, often for days on end, are the typical predisposing conditions. Its great military significance is that almost invariably it incapacitates front-line fighting groups, the greatest proportion of whom can never return to combat duty.

Medical opinion will not agree that trench foot is inevitable in the face of unfavorable environment conditions such as those existing on the western front, but nevertheless the current experience is a measure of the toughness of the problem. Shortages of equipment play an important but secondary role. Only particularly vigorous command action to enforce individual foot hygiene will hold admissions to a reasonable level and prevent a heavy and unnecessary drain on front-line fighting strength.

Treatment

The principles of treatment consist essentially of rest, avoidance of local trauma and infection, elevation of the feet to promote drainage of edema fluid and reduction of metabolism in the affected parts. The patient should be kept in bed with the lower legs and feet elevated on pillows slightly above heart level and protected from external pressure either by complete exposure or by means of a cradle. The period of bed rest is determined by the degree and rate of subsidence of edema and circulatory disturbances. Whereas the individual should be kept comfortably warm, maintenance of minimal tissue metabolism in the affected parts is important and the application of external heat to the feet must be avoided. In certain cases in which pain is prominent and persistent, actual cooling of the limbs may be indicated. Massage or rubbing of any sort in the early stages and all antiseptics and ointments should be avoided. The part should be handled as little and as gently as possible. Measures to prevent secondary infection, including tetanus, should always be instituted, and in cases with threatening infection, sulfadiazine by mouth should be used. Areas of necrosis and ulceration which may subsequently develop should be treated conservatively until surgical intervention becomes necessary.

Additional information concerning trench foot will be found in War Department Circular No. 312, dated 22 July 1944; War Department Technical Bulletin TB MED 81, dated 4 August 1944; and in the Bulletin of the U. S. Army Medical Department of November, 1943, page 26; March, 1944, page 46; June, 1944, page 91; and December, 1944, page 58.

The Pathology of Trench Foot*

The pathologic changes in trench foot have been studied at the Army Institute of Pathology. The studies were based on surgical specimens

and autopsy material. The injuries were incurred in Italy and the Aleutians and resulted from exposure to wet cold, in most instances the temperature having been above freezing. Secondary infection was common, and anaerobic gas-forming bacteria were cultured in several cases.

In three cases death had occurred seven to ten days after exposure, during the hyperemic and edematous phase. The lesions in these three early cases consisted of striking dilation and engorgement of the vessels of the skin and subcutaneous tissues. Agglutinative thrombi, composed chiefly of red cells and platelets with little fibrin, were widespread in the congested vascular tree. Hemolysis was also noted. The acute inflammatory reactions which were observed throughout the tissues presented no unusual features. Disintegration of axis cylinders and degeneration of myelin in peripheral nerves were already evident. The small and unmyelinated groups of sympathetic fibers in the nerve trunks appeared unaltered, but the large medullated fibers showed conspicuous involvement.

In eleven late cases amputation was performed because of gangrene one to five months after injury. Sections of a leg removed thirty days after exposure showed organization of thrombosed vessels. In the other late cases the vascular changes were those of endangitis obliterans resembling Buerger's disease. The degeneration, ischemic necrosis, and infarction present in both soft tissues and bone were succeeded by scarring and atrophy. The phagocytosis of lipoid and atrophy of fat in the subcutaneous adipose tissue were especially pronounced. In the muscle the lesions consisted of simple atrophy and ischemic changes comparable to those of Volkmann's contracture. Necrosis of bone without sequestration was followed by sheathing of the dead trabeculae with new osseous lamellae; the resultant picture is comparable to that of Sudeck's atrophy.

The anatomic changes observed in the present study and those described in previous reports have been evaluated in the light of modern concepts of the functional and morphologic effects of cold on tissues. It has been concluded that the conventional distinction between "true frostbite" and the injury produced by chilling when the freezing point is not reached should be abandoned since the tissue reactions follow the same disturbance in the circulation and the resultant vascular obstruction. The delayed sensitivity to cold which follows apparent recovery may be caused in part by the damage to the subcutaneous penniculus and is certainly related to the occlusive peripheral vascular disease.

*From The Bulletin of the U. S. Army Medical Department, Feb., 1945.

STATE POST WAR PLANS REQUESTED

AFFILIATED State Societies are requested to forward copies of state post war plans to the Executive Secretary. In preparing the annual report of the N. A. C. Post War Planning Council it is our desire to include summaries of all programs which are being designed for local operation. Your cooperation in this matter will be greatly appreciated.

DR. EDW. P. DURKIN, *Chairman*
N. A. C. Post War Planning Council

DIFFERENTIAL DIAGNOSIS OF VERRUCAE OCCURRING ON THE FEET WITH TREATMENT BY NEEDLE SURGERY

LOUIS M. NEWMAN, D.S.C.
Philadelphia, Pa.

THE TERM verruca vulgaris plantaris, or what is commonly known as plantar wart, implies that a verruca found on the foot occurs only on the plantar surface and consists of a definite circumscribed single or multiple callosity superimposed upon an area of papillary proliferation.

Although the aforementioned terminology aptly describes and represents, by far, the most common of the pedic verrucae, close observation by the chiropodist will discover the hitherto unpublished fact that warts on the feet are not necessarily relegated to only one simple textbook variety.

Verrucae of the foot, or pedic verrucae, may be classified clinically into the following four types:—

1—DISCOID—This represents the conventional, most common, variety of verruca, and occurs as a sharply defined, round or oval lesion varying in size from a pin-head to a silver quarter. It may appear singly, multiple, or in clusters. These verrucae are characterized by a flat, thickened surface, deep-seated with a moderate amount of keratosis. These lesions may be found anywhere on the sole of the foot, or the plantar and dorsal aspects of the toes. On the dorsum of the foot proper they have a predilection for the greatest site of shoe trauma, in a line running from the head of the talus, forward, to the 1st metatarsophalangeal articulation.

2—TUMOROUS—These verrucae are found, primarily, beneath the prominent weight-bearing points of the foot, such as under the sesamoids, the 5th metatarsal head, and the heel. Frequently, they are present in the interdigital spaces. Sizes vary from a small pea to a cherry. They are globular in form due to extreme hyperkeratosis. This type is by its nature very painful yet the least resistant to treatment. Tumorous verrucae rarely occur in clusters.

3—MOSAIC—This type occurs in a coalescence of shallow plaqular clusters with ill-defined lines of demarcation, the borders fading into the normal integument. The verrucous area is maculo-papular in appearance, and is smooth and soft to the touch. They occur most frequently in adults, particularly on the ball of the foot, and yet present a minimum of keratosis. These lesions are almost entirely aconthomatous in structure. Subjective symptoms are rarely present. Mosaic verrucae are by far the most resistant to treatment, and the prognosis least favorable.

4—DIGITATE—These are flat warts with finger-like excrescences growing from them. They are found on weight-bearing surfaces of the feet and are due to trauma of an abrasive nature. They vary in size from a pea to a goose egg, and are rubbery in consistency. These lesions arise with unusual rapidity and have a tendency to enlarge rapidly in circumference. These verrucae are rarely multiple, and usually occur unilaterally. They are relatively painless. Digitate verrucae are somewhat resistant to treatment, but paradoxically, in many instances, seem to disappear as fast as they came in spite of any treatment.

Treatment By Needle Surgery

NEEDLE SURGERY may be defined as that branch of injection therapy that deals with the regeneration or degeneration of body tissues by the injection of irritating solutions.

Types of Injection Fluids Used In Chiropodic Needle Surgery

1—NECROTIC solutions—require a local anesthetic in advance, and produce sterile abscesses resulting in subsequent white connective tissue organization.

2—SCLEROTIC solutions—usually have a local anesthetic already incorporated, and by infiltration between the tissue cells cause an induration and contraction with the subsequent formation of fibrous connective tissue.

3—PROLIFERATIVE solutions—have a local anesthetic incorporated, which when injected into or within the region of abnormal tracts or denuded areas causes the formation of vascular fibro-elastic connective tissue.

Of the above-mentioned solutions, only the sclerotics and necrotics are utilized in the treatment of verrucae. Of the two only the former is safe, practical and efficient.

Sclerosing Solutions Used In Chiropody

Quinine & Urea Hydrochloride (¼ to ½%) (E. W. Cordingly, Clinton, Ind.)

Quinine Hydrochloride & Urethane solution (E. W. Cordingly, Clinton, Ind.)

Bismuth Sodium Tartrate (1.5%) (Reuben H. Gross, New York)

5% Ethyl Alcohol in 2% Procaine Hydrochloride (Louis E. Markowitz, Bronx, N. Y.

Varisol (Abbott Labs.) (Joseph S. Bowman, Lebanon, Pa.)

Quinocaine (Farnsworth Labs.)

Benzyl Alcohol (1 to 6% sol.) in 2% Procaine

Sodium Morrhuate (5% sol.) in 2% Procaine

Dosage

1 minim to ½ c.c. depending upon type and strength of solution, size and variety of lesion, tolerance of patient, physical condition of patient, and resistance of the verruca to sclerosis.

Syringe

One cc. Tuberculin.

Needle

One-fourth inch, 25 gauge, rustless, intradermal.

Injection Technic

Although most sclerotic agents either have an anesthetic action in themselves, or have local anesthetics incorporated, it is, nevertheless, advisable first to anesthetize the verruca by a fan-shaped infiltration of 1 to 2cc. Procaine Hydrochloride solution (1 or 2%). Unless such a procedure is instituted in advance, the patient will experience an uncomfortable burning sensation or a hot flash radiating from the injected lesion. Elimination of all sensation in the verruca before the injection of the sclerotic will allow for a more cooperative patient and further facilitate treatment.

Before injecting the sclerosing solution caution should be observed to avoid removal of too much of the underlying callus tissue. Unless this advice is followed the solution will spurt out of the lesion, and the effects lost. The needle is introduced, with the bevel up, at the periphery of the verruca and forced downward at an acute angle toward the approximate center of the growth. The injection is given *intradermally*, keeping the point directly beneath the corneum. If the solution is deposited *subcutaneously* absorption will take place into the blood stream immediately, and the local effects lost.

After introduction of the needle, pressure is exerted upon the plunger of the syringe to dispel the contents. It will be found very difficult to inject the solution, and a great deal of force is required because of the resistance of the tissues. Unless this resistance is felt, the solution will not be injected at the proper site. If the solution enters easily, as a rule, no results will be procured. Immediately upon injection the verrucous area will become blanched and distended. Allow the foot to be raised for a few moments until a faint hyperemia is visible, then apply a light, sterile dressing. Advise the patient to return in 5 to 7 days. A protective shield is rarely necessary, and the part may be bathed and redressed in the interim as often as the patient desires. Should any painful symptoms arise at home the limb should be elevated, and ice compresses applied to the part until the acute symptoms subside. Pain, after injection, is an exception rather than the rule; in most cases the sclerosing fluid will have an analgesic effect upon an untreated, painful verruca. It is advisable to inject one verruca at a time in cases where multiple verrucae exist, unless the tolerance of the patient allows otherwise.

When the patient returns for subsequent visits a hemorrhagic area will be visible through the keratotic zone disclosing the effectiveness of the treatment. Sometimes it is necessary to remove some of the overlying tissue to reveal the papillary destruction. The hemorrhagic area in the early stages will disclose a reddish-brown liquid, which later hardens and shrinks into a solid mass. Upon removal of this eschar the tissues beneath will present a normal epidermis. One to three injections will suffice for complete involution of the average verruca. With extremely large verrucae several small doses may be given concurrently at different points along the margin of the lesion. An antiseptic dressing may be used to complete the treatment.

Advantages of Needle Surgery in the Treatment of Verrucae

1—Relatively painless.
2—Leaves no scar tissue.
3—No bulky shields or dressings are necessary.
4—Feet can be washed frequently.
5—In the great majority of cases results are certain and rapid.
6—Contraindications and idiosyncrasies are negligible.
7—Sloughing is eliminated.

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GIVE TO THE RED CROSS

PES EQUINOVARUS, UNILATERAL

Residual Poliomyelitis
A Case Report

LT. (J.G.) GUSTAVE S. BRAUN
U. S. Naval Reserve

ONLY OCCASIONALLY does a case involving a chronic deformity lend itself so dramatically for study. The reaction to each treatment in this case was so specific, that the clinical progress could be traced step by step to the eventual termination in an accommodated correction. In these clinical notes, the reader may notice the conspicuous absence of physiotherapy in the therapeutic regime. The decision not to use it was made early in the regime so that the progressive mechanical and physiological changes unfolding from treatment to treatment might be studied in their acute and most easily recognized form. Once the student appreciates these changes, the selection of the proper supplemental modality to combat each, will be simpler and their effectiveness proportionately increased. It is largely from an effort to demonstrate elemental treatment at its basic worth, that this case has been considered worthy of report.

Case Report

A. L. C., Apprentice seaman, age 36, weight 158, height 5′ 9″ was referred to the Foot Clinic.

Chief Complaint: Generally painful feet and improperly fitted shoes.

History: Had always had "bad feet," and had come to accept them. Reported infantile paralysis in first year of life affecting lower extremities. Doctor stated that use of extremities might be regained during second year of life. When no inclination to use limbs was noted by the eighteenth month, treatment was begun. Patient was vague on type and amount of treatment, but states that it was "fairly regular" until age six with apparently no result. Contracted pneumonia at this age and reported that after crisis, gained use of extremities for the first time. After recovery from pneumonia, learned to walk. Dragged left leg, but gait continued to improve until age twelve. No treatment during that period. Patient reported that limp was "hardly noticeable" at that age, and does not think there was any appreciable change since then. Patient demonstrated a rolling gait heavy on the left foot. Left foot and leg "continued to bother," but accepted pain with the philosophy that "he was lucky to be as well off as he was." Followed sedentary occupations successfully and without handicap in civil life until entrance into the service. Was picked out of the Receiving Line and sent to Medical Holdover for closer observation and decision on fitness for service. Patient's firm opinion that "he got along all right in civil life for thirty-six years and felt he could do the same in the service" was largely responsible for a decision by Medical Holdover of trial duty. The condition was noted in his health record as "Residual Poliomyelitis, extensor contractures to lessor digits, left foot."

Physical Examination: Well formed, intelligent appearing white male, negative except for extremities. Wearing size 8-F shoe which was acutely short on right foot, moderately short and narrow on left. Feet generally inflamed from improper shoes.

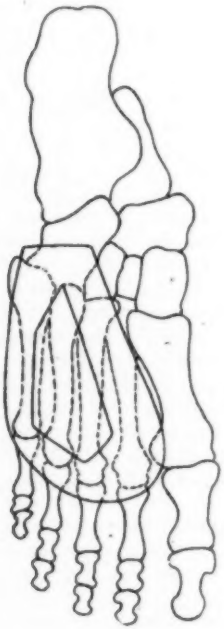
Right foot: In chronic strain. Balance and alignment satisfactory, musculature in general spasm.

Left Foot: In a slight equinus position, with the metatarsal segment slightly plantar-flexed and markedly adducted in relation to the tarsus. The tarsus was slightly supinated in relation to the leg. The entire

tarso-metatarsal articular line patho-mechanic, with particular trauma at its lateral aspect. Plantar fascia hypertensed and inflamed. Leg musculature in contracture spasm. Extensor tendons to the lessor digits in contracture with the toes "hammered." A large painful heloma present on the fifth toe. Passive reduction of the deformity was difficult but possible. Reflexes and circulation within normal limits. Extent of deformity; at rest, a continuation of the median line of the leg passed laterally to the fifth toe by 8cm.; on weight-bearing, through the fifth toe.

X-Ray Examination: Negative except for misalignment as noted above.

Diagnosis: Pes Equinovarus, unilateral, residual poliomyelitis.



METATARSAL BLOCK

FIGURE 1

It will be noted that this block is considerably larger than average conception for blocks in this area. Kinetic body mechanics dictate the lateral position to force the metatarsal segment into eversion and dorsi-flexion in relation to the tarsus. Intermittent traction is induced against the plantar fascia. The anterior transverse angle induces plantar-flexion of the lessor digits.

Treatment

Stretching and manipulation was routinely employed as the condition indicated at the time of treatment. Massage was used occasionally but largely to reduce edema when present. All blockings were of ¼" felt, skived to meet the exact requirements of kinetic body mechanics of the part in use. Figures 1 to 3 illustrate the blocks used. Adhesive straps securing these blocks sometimes controlled motion, but greater stress was placed on the effectiveness of the proper block. The following clinical progress notes concern only the left foot. The right foot presented no unusual problem and responded without event.

Clinical progress notes.

March 8: Metatarsal block, Fig. 1; advised split shoe size.

March 9: Shoe fit checked, Right 9-E; Left 8½-F, satisfactory.

March 11: Progress; Painful stretching throughout extremity including the thigh. Deep fatigue in the peroneal group.

Treatment; Long lateral block, Fig. 2.

March 15: Progress; Painful stretching continued in extremity, abating in thigh. Aching in peroneal group. Foot mildly inflamed throughout.

Treatment; Metatarsal block, Fig. 1.

March 18: Progress; Painful stretching abating in leg, absent in thigh. Less ache in peroneal group,

less tension in plantar fascia, improved motion throughout foot, but inflammation noted after last treatment increasing. A mild tenosynovitis in extensor tendons to lessor digits.

Treatment; Long lateral block plus cuboid block, Figs. 2 and 3.

Foot in normal position while blocked on weight-bearing.

March 21: Progress; Fatigue in leg, notably in peroneal group. Tension in plantar fascia and extensor contractures almost completely overcome. Tenosynovitis of extensor tendons subsiding. Entire foot slightly edemous with a slight increase in local temperature. A well defined, mild synovitis present.

Note: Patient had detail in swimming pool during this period and did not wear shoes, thereby receiving maximum fulcral and functional effect from the blockings. Foot in normal position without blocks on weight-bearing.

Treatment; Long lateral block, Fig. 2.

March 24: Progress, Peroneal group showing increased tone. Synovitis markedly abating with only pronounced pain remaining in the metatarso-phalangeal articulations. Some pain also present at anterior attachment of plantar fascia. Heloma of fifth toe absent. Foot in normal position at rest.

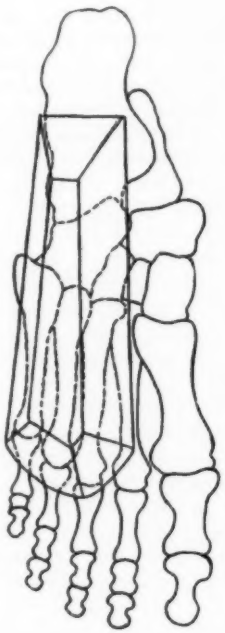
Treatment; Metatarsal block, Fig. 1.

March 27: Progress; Patient asymptomatic except for fatigue. An involuntary "jerk" was noted in the peroneal group with the part at rest, pulling the foot toward a corrected position. Deep palpable pain could be elicited along the entire course of the plantar fascia and in the calcaneo-cuboid articulation. This last was due to the final reduction of metatarsal varus. Shoe feeling short, was refit in 9-E.

Treatment; Long lateral block plus cuboid block, Figs. 2 and 3.

Patient departed on a seven-day recruit leave. While on leave, reported activity never before possible. Danced with enjoyment for first time in life. Fatigue and a slight pain in the heel only complaint after prolonged activity.

April 4: Progress; Mild bursitis present at posterior attachment of plantar fascia. Some soft tissue inflammation noted in region of sesamoids.



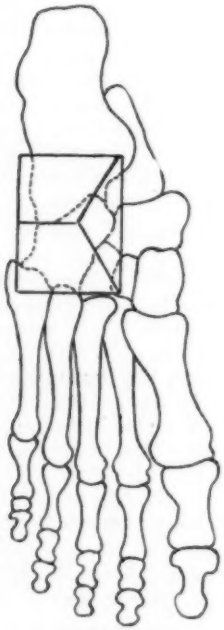
LONG LATERAL BLOCK

FIGURE 2

Eversion and dorsi-flexion of the metatarsal segment in relation to the tarsus, and improvement of tarsal balance in relation to the leg, is affected by this block. Note the acute lateral skived edge. This block acts as a soft splint to the pathomechanics at the lateral aspect of the tarso-metatarsal articular line.

Treatment; Long lateral block, Fig. 2.

Patient had been scheduled for transfer to the hospital for hemorrhoidectomy after completion of recruit training and return from recruit leave. On April 7 was sent to the hospital with instructions in self-manipulation and stretching to prevent possible retrogression toward deformity. Complications followed hemorrhoidectomy with the result that the patient was not discharged until July 1. Some returns to deformity resulted characterized by acute muscular spasms.



CUBOID BLOCK

FIGURE 3

This block, with its unskived lateral edge and high transverse plane at the calcaneocuboid articular line, forces the calcaneum from its position of varus and cavus, into one of straight cavus. Deformity is reduced from two planes to one. In combination with the long lateral block (Fig. 2), kinetic body mechanics flow in lines of normal stress. In combination as noted above, this block is applied first, with the long lateral block covering it.

July 5: Acute post-convalescent strain with deformity.

Treatment; Long lateral block, Fig. 2.

July 13: Painful stretching in musculature throughout foot and leg, for thirty-six hours to the point of not permitting sleep, then gradual reduction in intensity until time of treatment.

Treatment; Long lateral block, Fig. 2.

July 19: Progress; Acute neuritis along path of posterior tibial nerve following treatment, acute for twenty-four hours, then gradually subsiding during next seventy-two hours. Fatigue noted in leg toward evening with a return of the involuntary peroneal "jerk" noted in the progress notes of March 27.

Treatment; Long lateral block, Fig. 2.

July 21: Progress; Acute post-convalescent deformity absent at rest and on weight-bearing. Painful reaction in posterior tibial nerve starting in popliteal space on half hour after treatment and characterized by a sharp hot pain slowly descending along course of nerve during next half hour to terminate and disappear under the cuboid. Patient asymptomatic during rest of time except for mild ache through ankle when fatigued.

Treatment; Metatarsal block, Fig. 1.

Patient was seen on August 2, 8, 9, 14, 18, 28, and September 2, without event except as follows. On August 8, it was decided to add a modified Thomas bar to the shoe and eliminate further blocking of the foot. This bar was prescribed to give a ¼" lateral lift and skived to infinity toward the medial edge of the shoe. The patient returned

the next day (August 9) to check the application of the bar. This was satisfactory and the patient was advised to expect some moderate reaction of physiological strain in becoming accustomed to it. On August 14, patient retuned reporting heavy fatigue in leg and mild ache through ankle for first two days, subsiding on third day, and totally absent on fourth. On examination, only clinical evidence was mild soft tissue inflammation over sesamoids. On August 18, 28, and September 2, patient was given extremely mild metatarsal blockings, more in a protective than a fulcral sense. Patient discharged on September 2 with instructions to add bar to all present shoes. As shoes were replaced, bar was to be added only to duty shoes. Dress shoes were not to be accommodated. Bars on duty shoes were to be eliminated gradually during an approximate six-month period. These bars were considered a precaution rather than a necessity, since no evidence objective or subjective, of the original deformity existed at the time of discharge. This man was sent to the fleet for full duty.

Comment

This case was selected for report because it demonstrates so well, the practical application of fulcral therapy. Once the clinical picture is studied, the rationale should be equally clear. Reactions to each treatment are typical and expected. They were, however, more climactic than can be ordinarily observed. The very dramatic nature of these reactions, and the rapid resolution in correction, does, however, impell speculation on the etiology.

It is suggested that the paralysis which existed for six years was, at least in part, psychotic. Following the original illness, if it is assumed that external factors created some monosymptomatic hysteria, the recovery of function following pneumonia could be supported on the grounds of an effect of shock therapy. Under such circumstances, the physical findings would be essentially mechanical rather than functional, and a more rapid response to therapy would be logically expected.

While such reasoning is hypothetical, it is advanced in an effort to explain an almost phenomenal result on a condition that had been accepted as irreparable for thirty-six years. It seems that some such effort should always be made to support therapy or its results.

ARE YOUR N.A.C. DUES AND ASSESSMENTS PAID?

NATIONAL ASSOCIATION OF CHIROPODISTS

FOOT HEALTH WEEK

JUNE 8th-16th

BLUE-JAY ADVERTISEMENTS URGE "SEE A CHIROPODIST"

THE BAUER and Black Co. in its current advertising campaign for a new corn plaster containing nupercaine mentions in all the advertisements "For More Serious Foot Ailments See a Chiropodist."

DEMEROL

THE SEARCH for a drug with the potency of morphine for relief of pain, but which would not be habit-forming or possess the other undesirable effects of most opium derivatives, has resulted in the synthesis of demerol, the ethyl ester of l-methyl-r-phenyl-piperidine-4-carboxylic acid. In the form of the hydrochloride salt, this compound equals or surpasses morphine in some respects. Demerol is a safe drug, readily absorbed when administered orally, subcutaneously or intramuscularly, which possesses satisfactory analgesic and sedative action, a weak atropine-like influence, and a moderately strong papaverine-like effect upon smooth muscle.

Frederick F. Yonkman, M. D., Paul H. North, M. D., and Hans H. Hecht, M. D., of Wayne University Medical School, Detroit, explain the composite pharmacologic action of demerol, on the basis of the structural similarity to both atropine and morphine.

The mydriatic, antisalivary and vagus-depressing actions of the drug on the bronchi, intestine, uterus and blood vessels of various laboratory animals are well known.

When used for the relief of pain arising from lesion of joints, kidney, stomach and intestines, biliary tract, nervous system, bones, pleura or heart, demerol was completely successful in 64.2% of cases, partially effective in 23.6% and failed in 12.2%. Relief followed within five to twenty minutes when 100 mg. were given intramuscularly or within twenty to thirty minutes after oral administration of the same dose. The effect of such amount was greater than aspirin, but less than 1/4 or 1/6 gr. dose of morphine. Hypnotic or sedative action was never profound. Unpleasant or toxic symptoms were noted by 27.4% of the patients, but were severe enough in only 4.8% to necessitate discontinuance of the drug. Withdrawal symptoms, and certain other circumstances, indicated that addiction may occur, but apparently not to the extent that would be expected from long continued use of opium derivatives.

Yonkman, F. F., North, P. H., and Hecht, H. H., Demerol: A New Synthetic Analgetic, Spasmolytic, and Sedative Agent. I. Pharmacologic Studies. II. Clinical Observations. Ann. Int. Med. 21:7-34, 1944.

TYPICAL PARACHUTE INJURIES

BETTER SELECTION of men for parachute training and new training technics have reduced injuries due to jumping to about 1%. Four typical parachute injuries are described by Major C. Donald Lord and Lt. Col. James W. Coutts, medical officers at the Parachute School, Fort Benning, Ga. In the initial training stage the most frequent injury is a strain or tear of the right rectus muscle, with definite sharp pain in the abdomen similar to that in appendicitis. The injury occurs in climbing. In the second stage of training, in which emphasis is placed on tumbling, injury to the tip of the shoulder is most common. The double fracture, caused by landing by parachute in which both the tibia and fibula are broken, is the typical injury in the two final stages of training. Since a change in landing position, from one with the feet 18 inches apart to one with feet together on contact with the ground, has been adopted, this injury more commonly involves a fracture of the upper third of the fibula or a dislocation of its head, instead of breaks in both the tibia and fibula

near the ankle. The high break of the fibula causes only few, if any, symptoms.

TREATMENT OF EPIDERMOPHYTOSIS

TYPICAL VESICULAR and scaling lesions, with maceration, on the toes, soles and palms were healed in more than half of 50 unselected patients with a single application of a solution containing 10 Gm. of U. S. P. salicylic acid: 33 cc. of U. S. P. acetone; 33 cc. of 85% ethyl alcohol and 33 cc. of U. S. P. glycerol, according to W. B. Albert, Ph. D., of Clemson, S. C., and Rowland F. Zeigler, Jr., M. D., of Seneca, S. C. In a few cases two or three applications at five to seven-day intervals were required.

METATARSALS REVERSED IN COLLIER'S

AN ARTICLE captioned "Trouble Afoot" appeared in the Feb. 24, 1945, issue of Collier's magazine. It was based on an interview with Dudley J. Morton, M.D., and illustrated with a schematic drawing by Frank Netter, M.D. We have called the attention of our medical colleagues to the fact that the metatarsals are numbered in reverse on the drawing, the fifth being marked number one, etc. We feel sure that the average lay reader will be confused when comparing the text with the drawing.

GIVE TO THE RED CROSS

PUBLIC HEALTH CAMPAIGN FOR PHYSICAL FITNESS

ARMY, NAVY and civilian groups were represented at a conference of the Joint Committee on Physical Fitness in Chicago, August 28. Tasks of the committee, which was established by presidential order April 29, 1943, are:

1. To define and study problems relating to the promotion of physical fitness, in cooperation with national agencies and organizations, and encourage cooperative programs for their solution.
2. To serve as a center for the stimulation of state, district and local programs.
3. To make available to states, localities, organizations and agencies, upon request, the services of specialists.
4. To prepare materials and serve as a clearing house for information pertaining to establishment of a national program of physical fitness.

MATERIAL FOR PUBLICATION

Please send all material for publication to Dr. William J. Stickel, Editor, 3500 14th Street, N. W., Washington, D. C.

Scientific articles, organization announcements, committee reports and state society news should be sent to the above address. Manuscripts should be typewritten on one side of page only and preferably double-spaced.

EFFECT OF PROLONGED WET AND COLD ON THE EXTREMITIES

LIEUT. COLONEL RUSSEL H. PATTERSON
Medical Corps, Army of the United States

A STUDY is presented of cases of injury of the extremities due to prolonged exposure to wet and cold. These casualties from the taking of Attu were received at Letterman General Hospital twenty-six days after invasion of that island.

Approaching Attu, the soldiers were put ashore by inflatable rubber boats or landing barges. Some became wet during the landings and others, during the subsequent twenty-four hours in wading streams, seeking shelter from enemy fire, or advancing over snow-covered mountains. Within a few hours most of the men found protection in foxholes or trenches, often only two or three feet deep. Water seeped into their shelters from the tundra. A waterproofing grease had been applied to their boots but it was effective only a few hours. Some foxholes and trenches overlying rocky ground were actually dug in snow. Their footwear consisted of heavy, thick-soled, rather inflexible leather boots, extending to midcalf. They wore felt innersoles and two pairs of socks, at least one of which was wool. None had previously oiled the feet. Because of the inflexibility of this footwear, they could not exercise the feet and thus stimulate circulation. Enemy fire kept many in trenches or behind cover for days with almost no chance to remove their boots to massage the feet or change socks. Their hands were protected by knitted, five-finger, woolen gloves. Some also had leather gloves, but many did not wear them over the wool as they interfered with pulling the trigger. The gloves were almost constantly wet.

Exposure to wet and cold varied from three to fourteen days. They noticed, within twelve to twenty-four hours, throbbing, tingling, cramping, and increasing numbness of the feet. Many said, "We felt as if walking on wooden feet." Some had to crawl, thus sustaining extensive ulcerated lesion of the knees. On removal of the boots the feet were blue or mottled blue and white, swollen, and the soles were waxy white; those severely damaged soon became blistered, more swollen, and painful; the less severely damaged became red, hot, and swollen. Cramp in the foot and calf muscles was a prominent symptom.

The fingers became numb later than the toes, probably because the hands could be exercised, thus stimulating circulation. Numbness in the fingers occurred after about three days. Only one patient showed gangrene of a fingertip; nearly all, however, showed desquamation of

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The staff of the Letterman General Hospital cooperated in handling these cases and helped in the preparation of this report: Major Fred M. Anderson, M.C., executive officer of the Surgical Branch; Major Joseph McGuiness, M.C., chief of Clean Surgery Section; Major Clinton V. Ervin, M.C., chief of Septic Surgery Section; Major Charles F. McCluskey, M.C., chief of Anesthesia and Operating Section; and Captain Walter B. Macomber, M.C., chief of Plastic Surgery Section.

The reports on cases transferred to other general hospitals were of great help, especially the ones from McCloskey General Hospital, Hammond General Hospital, and Kennedy General Hospital.

This report was reviewed by Captain Mervin L. Chernow, M.C., who took an active part in the Attu Campaign.

the fingertips as well as slight swelling, hypesthesia, and a mottled, cyanotic color. None had more than first degree thermal trauma of the face or ears.

Initial Treatment

The initial treatment following exposure was varied and uncontrolled, in many cases consisting of measures the individual concerned thought best. Some soldiers massaged the extremities, others rubbed them with oil, others went to bed with no treatment at all, while most of them had applications of sulfathiazole cream or antiseptic followed by cotton padding and a dry dressing. Nearly all elevated the feet; apparently none were packed with ice bags, although exposure to cold and slow warming was said to have been advised in some cases. The soldiers had been warned previous to exposure not to rub the feet with snow, and medical officers had been cautioned against too vigorous massage.

Classification

The patients were classified at Letterman General Hospital in three groups. No patients with damage classified as first degree reached the hospital as casualties:

SECOND DEGREE: Desquamation only—average duration of exposure, 6.6 days; longest, 14 days; shortest, 3 days.

THIRD DEGREE: Death of thick layers of skin and subcutaneous tissue, involving loss of nails and tips of toes—average duration of exposure, 6.5 days; longest, 11 days; shortest, 4 days.

FOURTH DEGREE: Gangrene with loss of foot or the greater part of one or more toes—average duration of exposure, 6.4 days; longest, 9 days; shortest, 4 days.

Treatment of Second Degree Cases

The second degree cases fell into three classes. The most severe, 25 per cent of the total, had edematous, very warm, flushed feet, congested when dependent, dry and with anesthesia of most of the foot. Another group, 33 per cent, had absence of one or more pulses, cold sweaty feet, slight swelling and a lesser extent of anesthesia. The remainder, 42 per cent, had slight desquamation of the skin, good pulses, little or no swelling, and hypesthesia rather than anesthesia.

Many of these cases were transferred within ten days to other general hospitals where treatment was similar to that at the Letterman. This consisted of bed rest with moderate elevation of the feet under non-heated, wooden, hooded cradles, foot exercises once or more daily without weight-bearing, application of lanolin or petrolatum with light massage once daily, mild sedatives when necessary, and daily tepid whirlpool foot baths. Those with vascular spasm and cold sweaty feet were given one or more lumbar sympathetic procaine blocks. In most instances improvement of pulses, moderate reduction of perspiration, and a lessened tendency to swell resulted, but shortening of the convalescent period is doubtful.

Eventually, woolen socks and soft shoes were given to this group and exercises and physical therapy were continued, but as long as five months after exposure, patients complained of deep foot pains, superficial burning, and aching, worse on walking.

Many of these cases developed an unusual foot deformity. The great

toe pulls downward, the small toes upward, the toes may spread, especially between the great and second toes, and marked cavus of the foot develops. After five months this foot deformity was very common, and patients complained about it.

A study of pathological specimens showed that nerves and vessels of the feet had varying degrees of inflammation and degeneration. The short muscles of the foot were most affected since the long muscles receive their nerve supply further up the leg and away from the involved zone. With the small muscles of the foot badly damaged, the long ones take over. The long flexor to the great toe is stronger than the long extensor, so the great toe pulls downward. The opposite is true with the small toes, so they pull upward—hence the foot deformity.

Third and Fourth Degree Cases

On the day of admission these cases were dressed in the operating room under aseptic technique. No anesthesia was required. Superficial necrotic tissue that might impede free drainage was removed. Aerobic and anaerobic cultures were obtained from moist or infected areas, especially at the line of demarcation. Sulfathiazole powder was sprinkled over raw areas which were then covered with vaseline gauze and dry sterile dressings. Tincture of merthiolate was applied to the webs of the toes when epidermophytosis was evident. Padded plaster or Cabot splints maintained the feet in neutral position. Each patient was given a stimulating dose of tetanus toxoid. On the ward, the lower extremities were kept slightly elevated and at room temperature under hooded cradles. The dressings were infrequently changed.

Lumbar sympathetic block was done on thirteen of the class 3 and class 4 patients. The indiscriminate use of this procedure is inadvisable.[1 2 3 4 5 6] Criteria used in selection of patients were pain, diminished or absent pulses, hyperhidrosis and coldness of the feet. Ten cases showed diminished or absent dorsalis pedis pulses. Two showed diminished and one totally absent posterior tibial pulses. The strength of the pulse varied, being intermittently fairly strong, weak, or absent from day to day. Three of these cases were given bilateral lumbar sympathetic block, all showing return of, or increase in, the pulse for several hours to several days following the procedure. In one case with both dorsalis pedis pulses absent, three sympathetic blocks resulted in permanent return of good pulsations. Pulses in all seemed to improve more rapidly than most of those not subjected to block. Five cases complaining of pain were given unilateral block, using the other side as control, and all stated that numbness and pain were less following block. This persisted for only the duration of the block and no permanent effect was noted. Four cases with hyperhidrosis of the feet were blocked bilaterally with warming and drying noted only for the duration of the block.

Infections

The aseptic technique followed in dressings at Letterman General Hospital evidently was too late because, on the initial culture, all cases showed a variety of infectious organisms, hemolytic and nonhemolytic staphylococcus and streptococcus predominating but frequently mixed with *Bacillus pyocyaneus, Escherichia coli, Streptococcus viridans, Bacil-*

lus aerogenes, and *Staphylococcus albus.* Cellulitis was localized in most cases.

Clostridium welchii organisms were demonstrated by culture in two cases. The presence of gas-forming organisms was suggested by x-rays in these two and four other cases. All of these cases had gangrene involving nearly the entire foot. X-ray findings suggestive of gas bacillus infection consisted of circumscribed rarefied areas in the soft tissues of the gangrenous feet. These cases were given prophylactic x-ray treatment as advised by Kelly and Dowell.[6] The literature generally makes little mention of gas bacillus infection as a complication of immersion foot, trench foot, or frostbite.

In the past tetanus was a complication in such cases but there was not a case of tetanus in this series. All of these patients had received tetanus toxoid soon after admission to the Army and stimulating doses as prescribed by Army Regulations.

Clinically evident epidermophytosis between the toes was present in about 80 per cent of the cases. Patients with actual gangrene, for the most part, were those who stated they had had fairly severe athlete's foot.

Pseudomonas pyocyaneus was a persistent pest, a number of cases showing it clinically and by cultures on arrival, while others acquired it in spite of careful technique.

Amputations

Amputations were done on this series as follows:

1. Both feet, three cases, all through lower third of tibia.
2. One foot, two cases, one through lower third of tibia, one through upper third of tibia.
3. Half of one foot, one case.
4. All toes, both feet, four cases.
5. One or more toes (not included in 4 above), thirteen cases.

While most authors advise waiting for a definite and circumscribed line of demarcation and mummification before amputation, none of our fourth degree cases took this course, all retaining an edematous and inflammatory zone at the area of demarcation. At the same time, there was a tendency to a slow extension of infection, especially along fascial planes and neighboring small joints. As soon as a fairly definite zone of demarcation can be made out, the toes and portions of the foot should be amputated just distal to this zone. This was possible in five to eight weeks in this series. It might well be done earlier. When the whole foot is involved and a useful foot cannot be obtained, much time may be saved by a sleeve guillotine amputation well above the infected demarcating zone, the stump to be left open, to be followed later by plastic revision or reamputation. Compression bandage and skin traction should be used following the sleeve guillotine operations.[7]

Pathology

All feet amputated in this series were subjected to careful dissection and pathological examination. The most striking findings in these eight specimens consisted of spotty areas of organizing inflammatory reaction just above the zone of demarcation, together with varying degrees of demyelinization of nerves, and thrombosis and recanalization of arteries and veins extending to as much as 3 to 5 cm. proximal to the demarcating zone.

Skin Grafting

Injuries due to cold and burns are analogous in that the destruction of tissue is caused by thermal extremes. The end results are similar and the tissues react usually in like manner. It is generally recognized that the contractures and deformities resulting from extensive burns can be prevented only by early covering of the exposed tissues.

Grafts are applied to the amputation stumps and granulating areas, not with the idea of being permanent, but merely to cover the exposed areas as early as possible. After trying penicillin locally and also Dakin's solution, we decided that normal saline solution dressings, changed every three to four hours, in most cases prepare the areas for grafting in the shortest time.

Preventive Measures

Excellent articles[1 to 12 incl.] in the recent literature dealing with prevention and treatment of this condition indicate that the medical profession is familiar with accepted measures. These include gentle handling, elevation, refrigeration and gradual warming, asepsis, use of sulfa drugs, and wound cultures. Other adjuncts which may prove of value in early treatment include mechanical means to improve venous and lymphatic drainage from affected parts, oxygen administration; lumbar sympathetic block in selected cases, administration of heparin or dicourmarin, and snugly fitting dressings or splints.

It is of at least equal importance that the commanding officers and the enlisted men should have an intelligent appreciation of the factors concerned in causation and in treatment of these conditions, for the golden moments in prevention and treatment frequently will occur before the patient is first seen by a medical officer.

A regular function of command, therefore, should be to consider the following points:

1. Regular drills in care of the feet.
2. Proper footwear; waterproof shoes or boots of not too rigid construction and large enough to allow two pairs of heavy socks, while still not too tight. Extra dry socks should be available and also proper protection for the hands.
3. Elimination of soldiers with foot deformities, past foot disorders, and those physiologically sensitive to cold, such as those with marked basomotor instability.
4. Elimination of soldiers with foot infections of any kind.
5. Oiling or greasing of the feet before exposure and reoiling or greasing if exposure is prolonged.
6. When possible, having men relieved from duty if there is an indication that foot trouble is developing.
7. Early and adequate care including elevation, complete rest and gradual warming or refrigeration, with as nearly aseptic technique as possible.

The individual should be instructed as follows:

1. Keep moving, or if forced into foxholes, exercise feet as much as possible.
2. Change to dry socks twice a day if possible. If not possible, take off footwear, and bundle and wrap the feet, at least when sleeping. Use exercise and gentle massage, unless feet are completely numb, night and morning and, if possible, more frequently.
3. Avoid prolonged dependent and cramped positions.
4. Avoid constrictive clothing.
5. Do not traumatize; especially do not rub hard if feet have become numb.
6. Do not force continuance in action or walking after feet have become numb unless absolutely necessary.
7. Do not expose to heat.

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From THE BULLETIN of the U. S. Army Medical Department, April 1944

IMPORTANT NOTICE

WE ARE compiling a list of all practitioners who are serving on the staffs of public and private institutions (hospitals, clinics, homes for aged, industrial concerns, etc.) Please send the following information to the Executive Secretary as soon as possible.

1—Your name and address.
2—Name of institution.
3—How long have you been affiliated with the institution?
4—How much time do you spend in the institution?
5—Briefly describe your duties.

NOTICE

Extension of Time for Submitting Papers in "Symposium on Deodorants"

Sponsored by the Bristol Myers Co.

PRESIDENT JOHN D. WALKER has announced that the final date for submitting papers on "Deodorants" in the symposium sponsored by the Bristol Myers Co. and the N. A. C. has been extended to June 1, 1945. All rules previously announced are still in effect. Members are urged to prepare and send papers to the Executive Secretary on or before the date noted above.

THE

JOURNAL

OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

PODIATRISTS

PUBLISHED UNDER THE DIRECTION OF THE COUNCIL
BY THE NATIONAL ASSOCIATION OF CHIROPODISTS

DR. WILLIAM J. STICKEL, EDITOR
3500 FOURTEENTH STREET, N. W.
WASHINGTON, 10, D. C.

Address all communications intended for publication, matter relating to advertising, business or subscriptions to the Editor.

FOOT HEALTH WEEK JUNE 8TH TO 16TH, 1945
OFFICIAL ANNOUNCEMENT

1. Foot Health Week sponsored by the National Association of Chiropodists and its affiliated State Societies will be held during June 8th to 16th, 1945.
2. President John D. Walker has appointed Dr. Harry W. Weinerman Chairman of the N.A.C. Foot Health Week Committee.
3. State Societies are requested to create state committees to supervise the project among the various state and local divisions. Please send the names and addresses of all state and division chairmen of such committees to the Executive Secretary. Printed material will be shipped to these chairmen for distribution to members.
4. Posters, leaflets, mats, etc., will be distributed on a pro rata membership basis to each State Society without cost.
5. Releases will be sent to newspapers, magazines and radio stations throughout the country by the N.A.C.-F.H.W. Committee.

THE N.A.C. PROGRAM WILL CONSIST OF THE FOLLOWING:

1. A full page in Life magazine.
2. Distribution of reproductions of Life page to members.
3. Distribution of special leaflets and posters to be used by shoe and drug stores.
4. Distribution of mats for special F.H.W. announcements in local papers by state and local groups.
5. Send out publicity releases to newspapers and rádio stations.
6. Cooperation with manufacturers of pharmaceuticals and shoes.

A SUGGESTED STATE SOCIETY PROGRAM IS AS FOLLOWS:

1. Distribute N.A.C.-F.H.W. material.
2. Make contacts with local papers and radio stations.
3. Cooperate with shoe and drug retailers.

4. Sponsor publication of F.H.W. announcements in papers through the medium of mats provided by the N.A.C.
5. Sponsor special projects under your society's auspices (public lectures, clinics, schools, industrial plants, etc.)
6. Tie up F.H.W. with the national Physical Fitness Program.

The cooperation of each State Society, Division and individual member is necessary to insure the success of this public education program. State Societies are urged to proceed immediately as follows:

1. Appoint a chairman and state Foot Health Committee.
2. Plan local projects in connection with Foot Health Week.
3. Appropriate funds for local and statewide projects.
4. Make preparations for the distribution of N.A.C. material to all members.
5. Invite shoe and drug manufacturers, retailers, health agencies, schools, industrial firms, etc., to cooperate.

Further announcements and instructions will be published in the JOURNAL.

A neat card (4 x 5½ inches) showing only the Foot Health Week insignia as illustrated above, will be sent to members upon request. Display it in your office or reception room.

GIVE TO THE RED CROSS

FOOT DISORDERS IN THE ARMY AND THE NEED FOR CHIROPODISTS

NUMEROUS articles on "Trench Foot" have appeared recently in the medical and lay press because of the large number of combat troops who were afflicted with this injury during the winter military operations on the Western European battlefront. Army medical publications have devoted considerable space to descriptions of the condition, its prevention and treatment, all of which are characterized by the notable omission of mention of the service chiropodists could render in supervising prophylactic measures and in educating the men on the proper care of the lower extremities.

Our Army which boasts of hundreds of specialized branches, departments, bureaus, services, etc., admits the importance of sound health from the physical, moral and economic aspects of military life but apparently such admission is not extended to include the value and need for the professional services of approximately three thousand chiropodists now in the Armed Forces on a par with other specialized health activities of the Army.

Since the advent of building a large armed force we have known about the high percentage of rejections due to foot disorders among selectees. We are also aware that thousands of men were inducted who suffered from so called minor disabilities, which were aggravated into serious ailments as the result of a rigorous training program. From training centers and battle areas have come reports on the number of men disqualified for duty because of fungus infections, foot strain, blisters and a host of other disabilities brought on by long hours of arduous walking and standing under all sorts of difficult conditions (bearing heavy loads, rough terrain, etc.)

Now we are hearing about the ravages of "Trench Foot" and the more we hear about it, the greater becomes our wonder that Army authorities do not insist on a specialized service directed toward foot care.

The rather stand pat Army Medical Department reply that "orthopedic surgeons" are charged with the major responsibility of maintaining a foot health program has decreasing significance in the light of the increasing number of men who are obliged to report on "sick call" because of foot lesions. Even if the Army had a sufficiently large number of orthopedic surgeons to offer a fairly complete personal service in supervising foot care the fact remains that they could be utilized for the vast amount of other orthopedic services which are required.

Foot care is important and we reiterate our view that if all chiropodists in the Army were employed in an organized program to prevent and treat foot disorders the number of man hours lost would show a decided decrease and the cost of maintaining the military establishment would be lessened. The general health, fitness and well being of the men would be improved and Army personnel and the public would be aware that every possible means of protecting foot health was being used.

Every time we read of a high incidence of some form of foot disability afflicting our military personnel we are certain that the percentage would be much lower if chiropodists were properly assigned and incorporated into the Army organization.

Whenever you meet a soldier and discuss with him some of the prob-

lems which have confronted him during his period of service the conversation invariably brings out that he considers foot care one of the most neglected phases of military life. The National Association of Chiropodists has been conducting a vigorous campaign which is designed to impress our civil and military officials with the need for providing more efficient foot care by utilizing chiropodists and giving them the responsibility and authority to conduct and supervise a highly specialized program for the maintenance of foot health in the Army.

As the war progresses we are convinced that justification for our campaign can be found in the humanitarian, scientific and economic aspects of a problem of this magnitude.

F. C. C. PROPOSED ALLOCATION OF SPACE IN RADIO SPECTRUM JEOPARDIZES SHORT WAVE MACHINES

Write to Your Senators Without Delay

The Federal Communications Commission, Washington, D. C., published on January 15, 1945, its proposed allocation of space in the radio spectrum for the medical services which include short wave diathermy machines. The bands it is proposed to allocate to this service are so prohibitively narrow that to operate within them would entail the use of crystal-controlled machines. This type of machine is as yet untried in the hands of civilian physicians and hospitals, has a complexity of construction and operation comparable to that of a broadcasting station, would have an original cost two or three times that of present types of machines and an estimated 500% increase in cost of service and difficulty of service.

The report of the Federal Communications Commission contained no provision for allowing chiropodists, physicians, hospitals and manufacturers a reasonable time in which to liquidate their investment in equipment already on hand. The only statement made in the report bearing on this point is quoted as follows:

> "In the cases of most of the equipment already in existence which does not operate within the narrow channel assignment as well as equipment which may be manufactured in the future, there remains in general the alternative of shielding and filtering."

Shielding has not proven to be practical, is very expensive, and has been condemned as being impractical by substantially all manufacturers and organizations thus far having expressed an opinion or having had experience in the matter.

The Commission has invited an appeal to be filed by February 21, 1945, and argued orally after February 28, 1945, and this appeal will be filed, yet there seems little likelihood of the appeal having any effect upon the Federal Communications Commission in the light of their recently published proposed action. This is particularly true when it is considered that distinguished members of the medical profession who are representatives of its most outstanding organizations, together with representatives of the manufacturers, have over a period of many years without effect repeatedly appeared before the Commission and stressed the urgency of this vitally necessary therapeutic measure being allocated sufficient space in the radio spectrum so that its cost would not be dras-

tically increased and its availability to the ill and injured not progressively decreased.

The statement has been made that such allocations as are finally decided upon, in the very early future, are almost certain to become parts of impending international treaties, thereby assuming the effect of hard to change laws. It appears urgently essential that such effort as is to be made to forestall the burdensome results of being obliged to use crystal-controlled machines should be made now before the proposed Federal Communications Commission allocations become a law.

The Council on Physical Medicine of the American Medical Association has announced its intention not to appeal from the proposed allocations of the Federal Communications Commission. Appeals are being made on behalf of the American Hospital Association, American Congress of Physical Medicine, Committee on Medical and Surgical Applications, Panel 12, Radio Technical Planning Board, Physical Therapy Manufacturers Group of the American Surgical Trade Association and the National Association of Chiropodists.

When writing to United States Senators it will not be necessary to go into great detail—just a brief simple statement that you, the writer, would appreciate it if the Senator would request the Federal Communications Commission to allocate for therapeutic purposes a sufficiently wide band in the spectrum so that the cost of chiropodical, medical and hospital care would not be greatly increased and also that this valuable therapeutic measure would not be made unavailable to those needing it.

Please write promptly to both of your United States Senators asking them to protect your and your patients' interest in this matter. This appears to be the last opportunity. Only by this means and by immediate action can you hope for or expect relief from this proposed disastrous allocation.

MILITARY ASSOCIATION OF CHIROPODISTS (PODIATRISTS) FORMED UNDER THE AUSPICES OF THE NATIONAL ASSOCIATION OF CHIROPODISTS

THE NEED for an organization devoted to the special requirements of chiropodists serving the military was recognized by the 1943 House of Delegates of the National Association of Chiropodists. Accordingly, provision was made for the organization of the Military Association of Chiropodists and further action by the 1944 House of Delegates made the Military Association a branch of the N.A.C.

The Navy Department, Bureau of Medicine and Surgery, was informed of this action of the N.A.C. and a request was made for authority to organize the Military Association of Chiropodists, and permission sought for qualified personnel to participate. The request was forwarded to the Bureau of Naval Personnel which granted authority, dated 14 Dec. 1944. Article 92, U. S. Naval Regulations 1920, must be compiled with, and is quoted here. Article 92 "prohibits combination of officers for the purpose of influencing legislation, from remonstrating against orders or complaining of details of duty. Canvassing of personnel, for the purpose of obtaining members, during duty hours is to be prohibited."

The Military Association of Chiropodists will function to increase the efficiency of the chiropodists' service, to the military, by fulfilling the

need for the exchange of professional information, within the limitations of security, pertinent to the duties of personnel performing this special work. The organization will be conducted without expense to the government.

Membership in the Association is automatic and limited to members of the National Association of Chiropodists who are serving in the Armed Forces of the United States, who are honorably discharged veterans of service in the Armed Forces of the United States, or her Allies, who are serving in, or are honorably discharged from duty under the cognizance of the U. S. Public Health Service, who are serving in, or are honorably discharged from duty as members of National or State Guard organizations.

The president of the N.A.C. has made appointments in the Military Association of Chiropodists for the year 1945 during which time appointees will draft necessary regulations for the functioning of M.A.C. Those appointed are as follows: *Co-chairmen,* Lieutenant Commanders Otto W. Schuster and William F. Eads of the Navy. *Secretary,* Lieutenant (j.g.) C. R. Brantingham of the Navy. *Coordinator for the N.A.C.,* Dr. William J. Stickel. *Board of Advisors—Military Section,* Major Morton Hack of the Army of the United States, Lieutenants John Green, Robert Stewart, A. W. Patton, and Harold Hay of the Navy, Captains Richard McAleese and Thos. H. Stratton, First Lieutenant Charles Turchin of the Army of the United States and Captain John D. Walker of the Connecticut State Guard. *Veterans Section,* Drs. Walter Fields, Stewart E. Reed, Donald F. Kimball, F. P. Camissa, Harry W. Weinerman, M. K. Upshaw, L. A. Hansen, Lowell Purgett, Lester A. Walsh, Ben Kauth and John J. Mueller.

In the next issue of the JOURNAL OF THE N.A.C. we will publish a form which is to be filled out by prospective members of the Military Association of Chiropodists.

C. R. BRANTINGHAM, D.S.C.
Lieutenant (j.g.) H (S) U.S.N.R.
Secretary, M.A.C.

1945 N. A. C. Awards for the Adancement of Research, Study and Treatment of Fungus Diseases of the Feet

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Papers Must be Submitted by July 1, 1945.

Members who plan on submitting papers for consideration on the "Advancement of Research, Study and Treatment of Fungus Diseases of the Feet" are requested to notify the Executive Secretary of their intentions. It is hoped that a large percentage of our practitioners will accept the opportunities offered by the creation of the Awards. When your paper has been completed send it to the Executive Secretary immediately.

CHIROPODY IS ESSENTIAL, NOT CRITICAL

MICHAEL V. SIMKO, M.CP.
Secretary, Draft Board 23A,
Bridgeport, Conn.

CHIROPODY IS not considered a critical activity by the Selective Service System. The latest memo issued by the Selective Service headquarters in Washington presents a generous list of activities declared vital to the successful termination of the war. All the activities listed are specified as essential, but the activities printed in bold type are called *critical* activities.

Chiropody is found under the heading "Health and Welfare Services." It is not in bold type; hence it is essential but not critical. The bold type includes: physicians, surgeons, dentists, oculists, osteopaths, sanitary engineers and veterinarians.

The chiropodist then is subject to induction before the osteopath, dentist, etc. Since the supply of men in the age group 18 through 25 is about exhausted the call for registrants will affect the men in the group 26 through 29 years of age. While the calls last November were as low as 84,000, the quota for March has increased to 148,000. If the calls continue to increase, members of our profession stand a chance of being drafted regardless of their marriage status, unless the registrant can prove that a hardship case prevails in his particular condition.

A report from General Lewis B. Hershey, Director of the Selective Service System, discloses that at the present time there are approximately 828,000 men classified in Class IIA or Class IIB in the age group 18 through 25. On the other hand in this same age group there was a total of 340,000 registrants as of January 1, 1945, classified IIC.

IIA classification refers to a registrant engaged in essential civilian activity; IIB, war activity and IIC, agricultural activity. It is reported some 12,000,000 men and women are now in the armed forces.

General Hershey's report further reveals that since the need of the armed forces is for men under 30 years of age the only substantial source from which these men can be obtained, other than those who become 18 years of age each month, is from those who are now occupationally deferred either in industry or in agriculture.

955 Main St.

PREDISPOSITION OF THE HYPERMOBILE ANKLE TO SPRAIN

HYPERMOBILITY of the ankle joint is the chief predisposing factor toward sprain, and favors recurrence. The possessor of an unusually mobile ankle joint, unless endowed with well-developed leg musculature, is extremely liable to sprain from small twists and minor trauma. When ankle sprains heal rapidly, that is, within a week, Major J. Grant Bonnin, of the Medical Corps of the British Army, suggests that the affected ankle is probably of the hypermobile type and likely to sustain repeated sprains.

Hypermobility of the ankle joint may be inherited or acquired, that is, a weak fibular collateral ligament may rupture early in life from some unrecognized cause, leaving a susceptible joint, or repeated minor injuries may have been neglected, and the ankle consequently becomes vulnerable. Hereditary hypermobility occurs bilaterally and is more common in women than in men, because of the greater laxity of female ligaments. Injury to the

calcaneo-fibular ligament is the primary cause of unilateral hypermobility.

The mobility of the hind part of the foot depends upon the flexibility of the subtaloid and midtarsal joints. Normally, only plantar flexion occurs at the ankle but, in the abnormal joint, astragalar flexion may be as great as 25°. Lack of opposition, which allows the sole to be turned at right angles to the transverse axis of the ankle, is characteristic of the hypermobile ankle; the leg-foot profile resembles the curve of a hockey stick, with the outer surface of the calcaneous approximating a 45° angle to the leg line. Another sign of a loose ankle joint is excessive prominence of the talus; when inverted the outer outline of the weak ankle reveals three protuberances instead of the usual two — the external malleolus, the cuboid, and the anterolateral edge of the talus. The prominence of the lateral aspect of the head of the talus is produced by laxity of the midtarsal joint and limited mobility of the subtaloid joint.

Roentgenographic examination of all severe sprains should be made with the ankle inverted. Accurate diagnosis of ligamentous rupture is possible by roentgenograms focused at right angles to the bimalleolar axis of both ankles, with the patient under general anesthesia, for comparison of the appearance of the injured and the normal ankle.

Strengthening muscle control is the primary prophylactic measure. The peronei may be developed by eversion against resistance offered by a weighted shoe and pully device. Wedging the sole and heel 3/16 of an inch on the outside may overcome the tendency of the foot to twist. With women, lowering and broadening of the heel of the shoe is the first step; if this fails the heel may be floated outward. Patients whose work predisposes to sprain of a hypermobile ankle should be fitted with shoes stiffened on each side with thin steel. The strength of the steel and the height of the shoes should be adapted to the patient's build and activity.

INJECTION TREATMENT FOR FLAT FEET

Lieut. Comdr. Herbert E. Hipps and Lieut. High Neely of the Navy Medical Corps report success with the injection treatment of flat feet in the February, 1945, issue of the Naval Medical Bulletin. Good results were also obtained with normal feet that ached from overexertion.

The average hospital stay for this condition was reduced from about 33 days to six days. Usually after the second treatment the men said they wanted to return to duty.

To the surprise of the medical officers, the number of men coming to the hospital complaining of sore feet fell off 50% after the injection treatment was started. Fear of the new "needle" treatment, the officers believe, was enough to discourage the malingerers, misfits, dissatisfied men and those with only a very minor degree of foot discomfort.

The treatment follows the method of treating sprained ankles and other simple sprains. Procaine hydrochloride is injected through the sole of the foot into the sore, painful places. Then the patient lies face downward with his knees bent to a right angle and the bottoms of his feet are massaged with an alcohol sponge for about five minutes. He then is required to walk up and down about the ward about 25 times, which makes a distance of about a quarter of a mile. After that he is free for the day.

The injections followed by the walking are repeated every third

day. When the man is discharged from the hospital he is given a note requesting two weeks' light duty.

Besides speeding recovery, the injection treatment is not followed by nearly so many recurrences as other methods. The success of the treatment, the medical officers state, may be partly due to actual benefit to the foot and partly to the psychological effect on the patient. This last fits in with the 50% reduction in complaints of painful feet.

Stretching of the ligaments is considered the basic, major cause of persistent pain in all overused feet if infectious, degenerative, metabolic and gross injury cases are ruled out. With freedom from pain after the injection, the patient can continue to walk. This prevents loss of strength and tone in leg and foot muscles during the recovery period and also allows the ligaments to increase in strength since they can be used painlessly.

UNIFORMITY OF JUVENILE LAST MEASUREMENTS STUDIED

A REPORT was recently made public of a meeting held in Chicago at the time of the National Shoe Fair of a special committee appointed to study uniformity of children's and growing girls' last measurements. Those in attendance under the chairmanship of Owen W. Metzer, Wetherhold & Metzger, Allentown, Pa., were as follows:

Retailers: A. S. Aronson, Coward Shoe Co., New York; Carl Burgstahler, F. E. Foster & Co., Chicago, Ill.; Henry H. Dahl, Thayer McNeil Co., Boston, Mass.; Francis J. Lordon, Montgomery Ward & Co., New York.

Manufacturers: Mel R. Cronshaw, International Shoe Co., St. Louis, Mo.; Galen Horner, Lancaster Shoe Co., Elizabethtown, Pa.; L. V. Hershey, Hagerstown Shoe & Legging Co., Hagerstown, Md.

Last manufacturer: Joseph W. Holms, United Last Co., Boston, Mass.

The committee recommended that new standard measurements be adopted incorporating wider measurements across the bottom of the last at the ball and at the heel: more girth at the ball, waist and instep; sufficient allowance be made from ball to toe for growth; over-all measurements for length and toe expression be left to the manufacturer in order to preserve individuality of his product.

NATIONAL INVENTORS COUNCIL WANTS REAL NONSKID SOLE FOR NAVY

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Or, if you can find a successful method of welding light gauge aluminum, the Navy will be much obliged because it's having to take its aluminum lifeboats and liferafts riveted.

Those are items on a list of 25 so-called "inventive problems" which the Navy hopes American genius will solve.

The list was made public by the National Inventors Council at the request of the Navy Department. The council said that if anyone has any solutions or even suggestions he should sketch them along to the NIC, Commerce Department, Washington, D. C.

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MEMBERS INTERESTED IN POST GRADUATE OR SPECIAL COURSES ARE REQUESTED TO COMMUNICATE WITH THE EXECUTIVE SECRETARY

A SURVEY of members who desire courses leading to a degree is being conducted by the National Association of Chiropodists. Numerous requests for such courses by practitioners (especially those in the Armed Forces) have been received by the Executive Secretary. Members interested in taking such courses are requested to submit to the Executive Secretary their views on the type of courses wanted, subject matter, length of course and similar pertinent information.

With sufficient information available it will be possible to utilize the services of one of the N. A. C. committees or create a new committee which would undertake a study of the need for post graduate and special courses and offer recommendations concerning them to the colleges and the profession. This problem is being considered as part of the Post War Planning Program of the N. A. C. and your expressions will be appreciated.

Please note—this survey is only a preliminary measure intended to provide information.

Address your communications to the Executive Secretary.

LENGTH OF THE HUMAN FOOT

IN "HUMAN BIOLOGY" (Dec. 1944) Dr. Howard V. Meredith of the Iowa Child Welfare Research Station, University of Iowa, reports that the human foot seldom becomes twelve inches long. Among normal adults the longest foot observed was 12.4 inches in a Negro man and the shortest foot was 7.6 in an Indian woman. The average foot length for white men is 10.3 inches, according to the article.

Adult Negroes have longer feet than whites, and American Indians have shorter feet. A foot 10.7 inches long is normal for Negro men, 9.9 inches for male American Indians. The foot length of women for the various races averages 9.7 inches, 9.3 inches (for whites) and 9.0 inches respectively.

Women attending college a half century ago had smaller feet than women students today, their feet averaging 9.2 inches as compared with the present length of 9.4 inches. Likewise the feet of men in college from 1880 to 1910 were, on the average, two inches shorter than they were for the period 1920 to 1940.

The growth of a human foot slows greatly from the period before birth to early adulthood. Foot length doubles in one month during the fourth month before birth, but it takes nine months to double its length three months before birth. It takes four years to double the length it is at birth and eight years to double the length it is at six months. It is 18 years before a boy's foot is twice as long as it is when he is a year and a half old, Dr. Meredith found.

All of the information on human foot length for inhabitants of North and Central America currently accessible, including data from seven previously unpublished studies, were assembled by Dr. Meredith in an attempt to answer questions popularly asked about the development of the human foot.

While the average woman has shorter feet than the average man, at all ages from infancy to adolescence a woman's foot is nearer adult size than is a man's. At birth, white females have attained approximately 34% of their foot length at maturity, white males only 31%. At ten years of age girls have attained 90% of their eventual foot growth, boys only 82%.

Individual differences in foot length do not exceed half an inch during the several months preceding birth, and during the first year after birth they do not exceed one inch. The length of feet of ten-year-old children normally varies about two inches, and in adulthood feet may vary three inches in length.

The human foot may be identified without a microscope between five and six weeks following fertilization, although at that period the feet still lie approximately along the same axes as the shafts of the legs and there is no heel contour, Dr. Meredith states. By eight weeks individual toes are visible and the contour of the heel is indicated. At birth, baby boys have feet 3.2 inches long and the feet of the baby girls are about 3.1 inches.

NOTICE TO STATE SOCIETY PRESIDENTS

Please forward the names of the Chairman and members of your State Post-War Planning Committee to the Executive Secretary as soon as possible.

A "Help Win the War" Suggestion . . .

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LEGISLATION

CONNECTICUT

S.129 proposes to prohibit the use of the roentgen ray, the x-ray or radium for the therapeutic or cosmetic treatment of another person except either by or under the prescription, direction or supervision of a licensed physician, osteopath or dentist.

H.188 proposes to require the department of health to cause to be printed and mailed by June 1 annually a list of all registered practitioners of medicine, midwifery, chiropractic, osteopathy, naturopathy, chiropody, nursing or physiotherapy. The present law requires such a list to be printed and distributed prior to March 1.

IOWA

S.55 and H.80, to amend the laws relating to the issuance of licenses to practitioners of the healing art and allied vocations, proposes to make it a ground for the revocation of such licenses for the holders thereof to quote a guaranty, price, terms or other special inducement prior to consultation. The bill proposes, however, that the provisions just referred to shall not apply to barbers, cosmetologists, pharmacists or embalmers.

NEW MEXICO

H.21 proposes to exempt from the provisions of the emergency school tax act fees and charges made by hospitals, physicians, osteopaths, chiropractors or dentists for care rendered the sick or disabled.

NEW YORK

S.217, to amend the workmen's compensation act, proposed to authorize an injured employee when dental care is required to select any dentist authorized to do so to treat him.

PENNSYLVANIA

H.246 proposes to authorize the board of medical education and licensure to license, after examination, persons to practice chiropody, defined in the bill as "the diagnosis and treatment of ailments of the human foot." Such a license does not confer the right to amputate the leg, foot or toes or to use any anesthetic other than local or to treat any constitutional disease.

MARYLAND

S.306 proposed to enact a separate chiropody practice act and to create a board of chiropody examiners, to be selected by the board of medical examiners, to examine and license applicants for licenses to practice chiropody.

OKLAHOMA, WYOMING, ALASKA

It has been reported that bills affecting the profession have been introduced in the legislatures of Oklahoma, Wyoming and Alaska.

ENGLISH TITLES TO BE USED IN NEW U. S. PHARMACOPOEIA

ENGLISH titles will take first place, Latin titles second place in the new U. S. Pharmacopoeia, scheduled to appear in December, 1945, according to an announcement from Dr. E. Fullerton Cook, chairman of the U. S. P. Committee of Revision. Although medical members of the Revision Committee have been the chief advocates of this change, other users of the Pharmacopoeia besides physicians are expected to benefit, since the new style makes possible the grouping of related products in one place.

DR. H. L. HOFFMAN, *Chairman*
N. A. C. Pharmaceutical
Committee

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A limited number of Dr. Gottlieb's manuscript "Diagnostic Foot Surgery" are still available at five dollars per copy.

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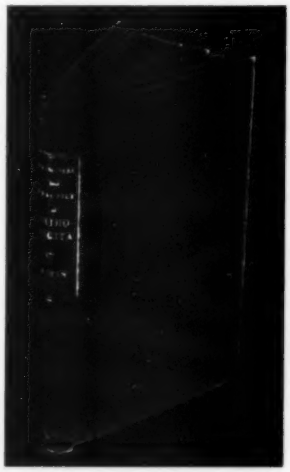

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STATE SOCIETY NEWS

MINNESOTA

A REGULAR meeting of the Minnesota Association of Chiropodists was held on Feb. 8, 1945, at the Lowry Hotel in St. Paul. Dr. Dow was elected a member and the application of Dr. Florence Patterson of Deer River, Minn., was voted upon. A discussion on Podonomy concluded the meeting.

RHODE ISLAND

THE REGULAR meeting of the Rhode Island Chiropodists Society was held in the Providence Biltmore Hotel on February 7, 1945. Prof. Altman delivered another lecture in his series on chiropodical pharmacy. A letter was received from Dr. McGauran regarding an article on the Wagner Bill which appeared in the Providence Journal. The Secretary was instructed to communicate with the Executive Secretary of the N. A. C. concerning it.

Members who have not yet paid their ten-dollar per capita assessment are urged to send in their checks immediately.

PENNSYLVANIA

North Philadelphia Division

THE REGULAR meeting of the North Philadelphia Division of the Chiropody Society of Pennsylvania was held on Feb. 13, 1945. Dr. Arthur Rappaport, Professor of Massage and Hydrotherapy at Temple University School of Chiropody, gave a lecture and demonstration on the "Kenney Treatment in Infantile Paralysis." Dr. Rappaport attended the Kenney Clinics at the Philadelphia Municipal Hospital.

Philadelphia Chiropody Society

THE REGULAR meeting of the Philadelphia Chiropody Society was held on Feb. 13, 1945, at the Sylvania Hotel. Albert H. Domm, M.D., of the Philadelphia General Hospital, discussed "Sulfonamides and Penicillin, Their Origin and Uses."

Several official communications from Selective Service were read concerning current policy as it applies to the profession of Chiropody. H.B. 246 has been introduced in the Pennsylvania State Legislature. The bill is now in Committee and it was pointed out to the membership that the passage of the bill can only be assured, if the whole-hearted support and cooperation of everyone is given.

Dr. N. H. Blumberg of the Post-War Planning Committee reported that the educational feature of our original plan is now available for returning servicemen. Dr. Chas. E. Krausz, Dean of Temple University School of Chiropody, has opened the clinics and classes for refresher courses to all ex-servicemen without cost. Anyone now in service desiring more information please write to Dr. N. H. Blumberg, Pennsylvania Bldg., 15th and Chestnut Sts., Philadelphia, Pa.

WYOMING

A REORGANIZATION meeting of the Wyoming Association of Chiropodists was held at Casper, Wyoming, on December 17, 1944. The following were elected officers:

John W. Scott, President, Sheridan; Frank Mendicino, Vice President, Cheyenne; Louis A. Catellier, Sec.-Treas., Cheyenne; Duane New-Schultz, Sergeant-at-Arms, Torrington.

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Executive Board: G. T. Brooks, Douglas; R. Masek, Cheyenne; J. Xinos, Thermopolis.

Louis A. Catellier, N.A.C. Councilman.

A resolution was adopted to establish a free foot clinic in St. Joseph's Orphanage at Torrington, Wyoming. The Association will bear all the expenses. A copy of our resolution was sent to the Most Reverend Patrick A. McGovern, Bishop of the Diocese of Cheyenne.

The N. A. C. Assessment of ten dollars per capita was approved and the secretary was instructed to forward the money to the Executive Secretary of the N. A. C. The meeting closed with a dinner at the Townsend Hotel.

CALIFORNIA ASSOCIATION CONDUCTED SUCCESSFUL WAR BOND DRIVE

"The California Association of Chiropodists, Inc., Northern Division, recently put on a War Bond Campaign to 'pay for' chiropodist equipment. During the six-week campaign, the $100,000 goal was passed by $88,300. So successful was the Drive that the Association's War Bond Committee immediately started to interest the National Association in a similar drive for the Sixth War Loan.

Women played a large part in the Northern California Drive. Women doctors and office nurses bought Bonds themselves and the nurses canvassed every patient during the campaign period, knowing that people who were benefiting from the latest equipment would be eager to sponsor similar equipment for the armed forces."

From "Home Front Journal"
Dec., 1944.

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BOOK NOTICE

STRUCTURE AND FUNCTION AS SEEN IN THE FOOT

By Frederic Wood Jones, D.Sc., F.R.S., F.R.C.S., and Professor of Anatomy, University of Manchester, England. Cloth. Price, $7.50. Pp. 329, with 150 illustrations, Baltimore; William Wood & Company, 1944.

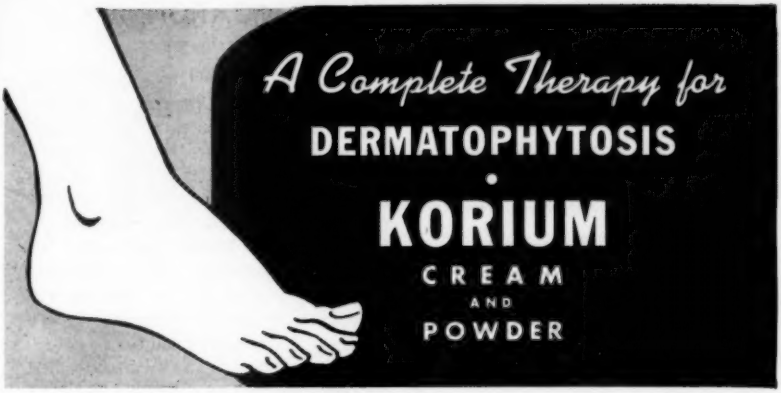
This comprehensive monograph is purely anatomic, including comparative anatomy and biomechanics, i. e., function. The illustrations are profuse and highly instructive. The book will be of interest to chiropodists, although there is no consideration of diagnosis or treatment.

For the practitioner who is treating the disabilities of the human foot it is important that knowledge of the part should be of the intimate kind by which each bone, ligament, joint and muscle is known as an individual entity. The volume is extremely helpful in this respect.

It is especially recommended to teachers of anatomy, physiology, surgery and orthopedics in chiropody colleges.

DR. LOGAN CLENDENING DIES

THE DEATH of Dr. Logan Clendening of Kansas City, Mo., was reported on Jan. 31, 1945. He was an honorary member of the National Association of Chiropodists. Dr. Clendening was a well known medical teacher and in his syndicated health column he frequently praised the value of chiropodical service and the importance of foot care. His passing will be noted with sincere regret among members of the profession.



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COMMUNICATION

Dear Editor:

Members of the profession should read more books. I am surprised to learn that the percentage of podiatrists who buy and read books dealing with the care of the feet is very small. I have always relied greatly on my medical library to keep myself informed on new developments. I consult my books frequently as an aid in understanding foot lesions which are presented in daily practice.

College training is necessary but it is not the alpha and omega of an education. It only serves as the background which enables one to acquire further knowledge. Someone has said that a formal education is much like an iceberg, about one seventh of which sticks out above the surface of the water and six sevenths remains below the surface.

In my opinion the exposed one seventh represents college training while the unexposed six sevenths represents the use which is made of the one seventh in acquiring greater knowledge. While post graduate courses and conventions have a definite place in continuing our education, they cannot replace the use of books. I hope that more of us will purchase and read books.

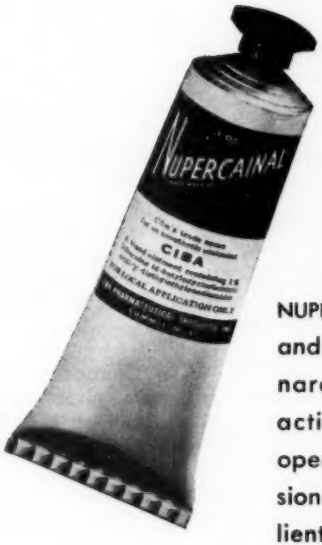
E. C. Rice, M. D.

DEATH REPORTED

Henry C. Schmidt

Dr. Henry C. Schmidt of Geneva, Ill., has been reported "killed in action" while serving with the U. S. Army in France. He was a graduate of the Illinois College of Chiropody in the Class of 1939. Following his graduation he practiced in Chicago. Dr. Schmidt was a member of the Illinois Association of Chiropodists.

NUPERCAINAL in Podiatry



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HONOR ROLL
to March 5, 1945

THE Honor Roll is published to acknowledge contributions toward special programs of the N. A. C.—Public Education, Post War Planning, Research and other projects which are sponsored for the benefit of the public and profession.

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CLASSIFIED ADVERTISING SECTION

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WANTED—A vibrator or percussor outfit in good condition. Describe and give price wanted. Write K. A., c/o Wm. J. Stickel, 3500 14th St., N. W., Washington 10, D. C.

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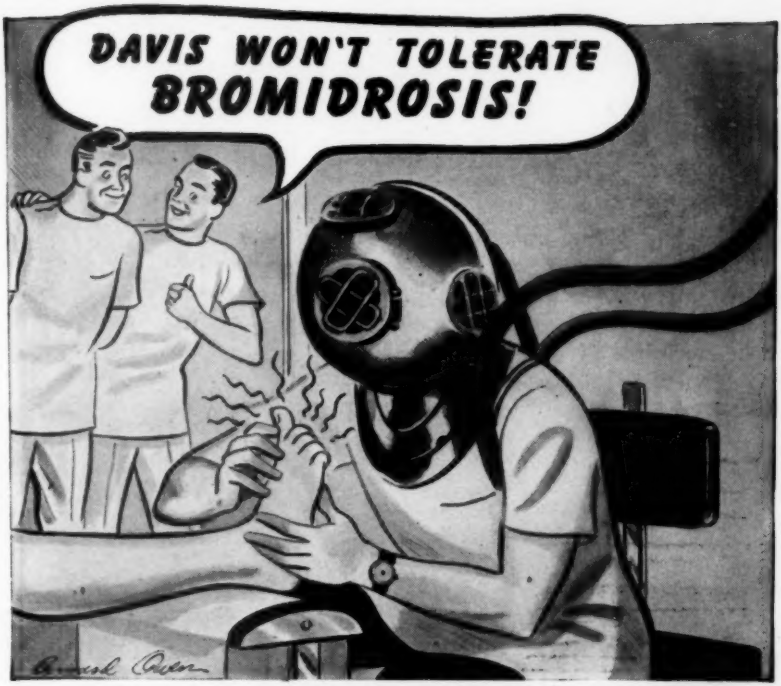

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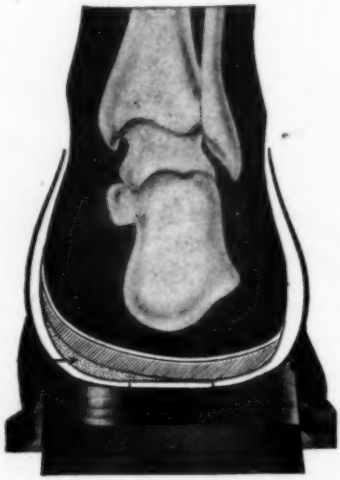

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